



Yale Journal of Health Policy, Law, and Ethics

Volume 5

Issue 1 *Yale Journal of Health Policy, Law, and Ethics*

Article 17

2005

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Recommended Citation

Aaron S. Kesselheim & Troyen A. Brennan, *The Swinging Pendulum: The Supreme Court Reverses Course on ERISA and Managed Care*, 5 YALE J. HEALTH POL'Y L. & ETHICS (2005).

Available at: <https://digitalcommons.law.yale.edu/yjhple/vol5/iss1/17>

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The Swinging Pendulum: The Supreme Court Reverses Course on ERISA and Managed Care

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INTRODUCTION

The critical issue in health policy is the cost of health care, and its importance will only rise further with the changing demographics of the U.S. population. The last twenty years have seen numerous efforts to control costs, beginning with regulatory mechanisms¹ and later dominated by the market-based approach of managed care.² At its peak, managed care led to a historic decrease in the rate of inflation in health care costs.³ Over the last five years, however, managed care has retreated significantly in favor of consumer-driven health care, in which individual patients are more exposed to the costs of care and thus choose more carefully which services to purchase.⁴

Federal and state regulation, as well as common law litigation, helped hasten the abandonment of managed care and the subsequent embrace of consumer-driven health care.⁵ In the 1980s and early 1990s, as a result of

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1. See TROYEN A. BRENNAN & DONALD M. BERWICK, *NEW RULES: REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE* (1996).

2. See JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE* (1999).

3. See Katharine Levit et al., *Health Spending in 1998: Signals of Change*, 19 HEALTH AFF. 124 (2000).

4. See James C. Robinson, *Reinvention of Health Insurance in the Consumer Era*, 291 JAMA 1880 (2004).

5. See M. Gregg Bloche & David M. Studdert, *A Quiet Revolution: Law as an Agent of Health System Change*, 23 HEALTH AFF. 29 (2004).

the Employee Retirement Income Security Act (ERISA),⁶ insurance companies designed managed care strategies without significant state supervision.⁷ ERISA established national standards for employer-sponsored benefit plans, rendering certain state laws inapplicable for enrollees in employer-sponsored health plans and limiting their ability to sue their managed care companies. As consumer dissatisfaction with elements of managed care grew, however, federal courts found themselves under increasing pressure to restrict this pre-emptive effect and allow more effective oversight of managed care tactics.

Starting in 1995, and fueled by three decisions since 2000, the Supreme Court has helped spur a judicial movement to limit the boundaries of ERISA preemption. The Court seemingly acceded to popular concern about the role that courts' support for ERISA preemption had originally played in the growth of managed care. This retreat weakened managed care, as executives and shareholders of managed care companies grew concerned about the costs of litigation and complying with state regulation, and the publicity gave further voice to the opposition to managed care practices.⁸ Experts agreed, "[T]he free ride enjoyed by health maintenance organizations is now over."⁹

Thus it is an extraordinary surprise that in its recent decision in *Aetna Health v. Davila*,¹⁰ which involved a state statute intended to protect managed care enrollees, the Supreme Court reversed course and reiterated its pre-1995 broad ERISA preemption doctrine. Few, if any, health law experts anticipated this event.¹¹ In the wake of this reversal for consumer and physician interests, we reexamine the development of ERISA law prior to *Davila* and present a vision of the immediate implications of the decision. We conclude by suggesting that *Davila* may represent the first swing of the pendulum back toward managed care.

A REVIEW OF MANAGED CARE LITIGATION AND REGULATION

Much has been written about the development of managed care in this country.¹² Briefly put, due to the benefits of the Health Maintenance

6. 29 U.S.C. §§ 1001-1461 (2000).

7. See Wendy K. Mariner, *What Recourse?—Liability for Managed-Care Decisions and the Employee Retirement Income Security Act*, 343 NEW ENG. J. MED. 592 (2000).

8. See James C. Robinson, *The End of Managed Care*, 285 JAMA 2622 (2001).

9. Marc I. Machiz, *Hidden Blow to HMOs*, NAT'L L.J., July 3, 2000, at A19.

10. *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488 (2004).

11. See Bloche & Studdert, *supra* note 5, at 35.

12. See, e.g., WALTER A. ZELMAN & ROBERT A. BERENSON, *THE MANAGED CARE BLUES AND*

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Organization (HMO) Act of 1973,¹³ nascent managed care organizations (MCOs) gained a competitive advantage over traditional insurers in terms of the premiums that they could offer to employers. HMOs, particularly those that employed medical staff and emphasized the use of guidelines to dictate care delivery, controlled physician decision-making by inducing compliance with algorithms designed to provide the most cost-effective care.

Seeing reduced expenditures, traditional insurers organized their own managed care plans, relying on tighter networks of physicians who agreed to managed care techniques—such as prospective utilization review, primary care gate-keeping, and relatively careful prior approval.¹⁴ Though the Clinton Health Plan was rejected by Congress, some of its principles still diffused out into the marketplace. As a result, even the hospital industry began to reorganize along the lines of primary care gate-keeping and prospective capitated payment. In many metropolitan areas, hospital utilization and ancillary testing were reduced, and health care inflation slowed to historically low levels.¹⁵

Patients and their advocates, however, began to recognize that many managed care organizational structures reversed the financial incentives in the doctor-patient relationship. In indemnity care, the physicians increased income by providing more care; in managed care, physicians' profit motive was no longer aligned with elaboration of services, and patients began to worry whether that could lead to restrictions on needed care.¹⁶ Patient advocates appealed to state legislatures to help regulate MCOs,¹⁷ and patients brought increasingly potent suits alleging harm by MCOs for denying them appropriate benefits.¹⁸ But these efforts, which challenged care reduction techniques at the heart of managed care, often bumped up against the ERISA preemption doctrine.¹⁹

HOW TO CURE THEM (1998).

13. Federal HMO Act of 1973, Pub. L. No. 93-222, 87 Stat. 914.

14. Robinson, *supra* note 8, at 2624.

15. Levit et al., *supra* note 3, at 124.

16. See Jon Gabel, *Ten Ways HMOs Have Changed During the 1990s*, 16 HEALTH AFF. 134 (1997).

17. See Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399 (1996).

18. *Jones v. Chicago HMO Ltd. of Ill.*, 730 N.E.2d 1119 (Ill. 2000); *Petrovich v. Share Health Plan*, 719 N.E.2d 756 (Ill. 1999).

19. See Alice A. Noble & Troyen A. Brennan, *Managing Care in the New Era of "Systems-Think": The Implications for Managed Care Organizational Liability and Safety*, 29 J.L. MED. & ETHICS 290 (2001).

ERISA AND MANAGED CARE ORGANIZATIONS

ERISA sets a national administrative standard for employer-sponsored pension and benefit plans, making them more palatable for large employers who would otherwise be subject to fifty different state regulatory schemes. The law also establishes a national remedy for failure to provide ERISA-sponsored benefits, limiting damages to the costs of the denied benefit and attorneys' fees. ERISA removes employer-sponsored plans from the control of any state law that "relates to" the management of plan benefits.²⁰ The ERISA "savings clause" allowed legislation that regulates the general business of insurance to stand,²¹ but it was interpreted narrowly in early decisions and does not apply to regulation specifically directed at MCOs.²² Although ERISA does not establish a uniform standard for all health plan administration, it impacts the large number of consumers who obtain health insurance through their employers.²³

This design has had two significant results. First, state laws did not apply to some important business practices of MCOs.²⁴ A state, for example, that required plans to cover annual mammograms for women at a certain age could only apply to government-sponsored or individually-purchased health plans. Second, even if plans inappropriately delayed claims or denied coverage for a treatment, enrollees could not sue under their state's common law of negligence, thus denying them consequential damages, punitive damages, or compensation for emotional distress.²⁵ Instead, such enrollees could receive only the ERISA remedy. When a patient sued her health plan for negligently denying approval for an autologous bone marrow transplant and high-dose chemotherapy in treating her breast cancer, she won an \$89 million damage award in state court.²⁶ Her plan was state-sponsored; if she had been in an employer-sponsored benefit plan, her award would have been limited in federal court to the cost of the procedure and attorneys' fees. This so-called "regulatory vacuum"²⁷ likely contributed to the excesses of managed care

20. See 29 U.S.C. § 1144(a) (2000).

21. See *id.* § 1144(b)(2)(A).

22. See, e.g., *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

23. Peter D. Jacobson & Scott D. Pomfret, *ERISA Litigation and Physician Autonomy*, 283 JAMA 921 (2000).

24. *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

25. See *Corcoran v. United Healthcare*, 965 F.2d 1321 (5th Cir. 1992).

26. David M. Studdert & Troyen A. Brennan, *The Problems with Punitive Damages in Lawsuits Against Managed-Care Organizations*, 342 NEW ENG. J. MED. 280 (2000).

27. Jacobson & Pomfret, *supra* note 23, at 921.

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during that era, as MCOs made large profits exploiting physicians and hospitals in negotiation tactics and limiting services to enrollees.²⁸

As a result, in the 1990s, advocacy groups pushed the federal government to amend ERISA to bring it in line with the modern reality of the health care marketplace.²⁹ While Congress did not reform ERISA, these efforts found a receptive audience in state legislatures, where popular opinion helped inspire legislators to try to rein in the well-publicized excesses of managed care. States protected enrollees by mandating certain inclusions in their health plans—for example, requiring certain benefits like mammograms,³⁰ providing independent review quickly when coverage was denied,³¹ and mandating prompt payment to physicians.³² Meanwhile, aggrieved enrollees looked to hold MCOs accountable for their business practices by making claims, akin to common law negligence arguments, that MCOs were liable for the injury-causing decisions of providers under their control. But as originally interpreted, ERISA preemption made these legislative and judicial efforts moot for many MCO enrollees.

A NEW PREEMPTION ANALYSIS

The Supreme Court's early comments on ERISA preemption solidified a long-standing broad judicial interpretation of the "relates to" clause.³³ In two 1987 cases, the Supreme Court called ERISA "a comprehensive civil enforcement scheme"³⁴ and seemed to favor arming ERISA with "extraordinary pre-emptive power."³⁵ In the 1990s, however, as MCOs expanded their influence over the health care system—and their profits—

28. See Wendy K. Mariner, *State Regulation of Managed Care and the Employee Retirement Income Security Act*, 335 NEW ENG. J. MED. 1986 (1996).

29. Cf. Bipartisan Patient Protection Act, S.1052, 107th Cong. (2001).

30. See Vicki L. MacDougall, *Medical Gender Bias and Managed Care*, 71 OKLA. CITY U. L. REV. 781 (2002).

31. See Aaron S. Kesselheim, *What's the Appeal? Trying To Control Managed Care Medical Necessity Decision Making Through a System of External Appeals*, 149 U. PA. L. REV. 873 (2001).

32. See Healthcare Fin. Mgmt. Ass'n, *State Prompt Payment Laws At-a-Glance*, at http://www.hfma.org/resource/focus_areas/commercial_payment/promptpay.htm (last visited July 1, 2004); Conomikes, *Summary of State Prompt Payment Laws*, <http://www.conomikes.com/PromptPay.htm> (last visited Dec. 5, 2004).

33. See Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29 (1999).

34. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

35. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65 (1987).

the Supreme Court moved to limit the scope of preemption using three different legal avenues.

First, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, the Supreme Court re-examined the “relates to” clause in the context of a New York state statute that imposed extra surcharges on patients covered by commercial insurers or HMOs.³⁶ A group of commercial health insurers sued to have the statute invalidated, and the lower federal courts agreed that ERISA preempted this state law that affected employee benefit plans by increasing their costs of doing business. On appeal, however, the Supreme Court unanimously upheld the statute because the impact of the rate-setting law was remote. Justice Souter concluded, “If ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course.”³⁷ He placed the first restriction on ERISA’s reach by limiting the scope of the “relates to” section, and in doing so prevented ERISA preemption from undermining a state law designed to reduce health care costs and improve access.

More generally, the Court seemed to change its attitude toward ERISA. Justice Souter confronted the broad path that preemption was carving in health care, remarking that nothing in ERISA indicated “that Congress chose to displace general health care regulation, which is traditionally a matter of local concern.”³⁸ The opinion implied that ERISA would not completely block reform efforts.

The Court demonstrated an awareness of its role, mediated by ERISA, in changing health policy. As a result, some statutes and cases once considered preempted under the broad reading of ERISA now found receptive lower courts. In *Dukes v. U.S. Healthcare*, for example, the plaintiff sued his MCO for not taking reasonable care in selecting and monitoring its physicians. The Second Circuit Court of Appeals held that ERISA did not preempt his claim, since it did not involve withheld or delayed benefits.³⁹ The Fifth⁴⁰ and Eleventh⁴¹ Circuit Courts also found instances where ERISA did not preempt suits against MCOs for negligence.

The *Dukes* distinction predicted the second technique the Supreme

36. N.Y. PUB. HEALTH LAW § 2807-c (McKinney 2002).

37. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 655 (1995).

38. *Id.* at 661.

39. *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995).

40. *Roark v. Humana*, 307 F.3d 298 (5th Cir. 2002).

41. *Land v. Cigna Healthcare of Fla.*, 339 F.3d 1286 (11th Cir. 2003).

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Court employed to limit ERISA—redefining MCO decision-making. In *Pegram v. Herdrich*,⁴² Dr. Lori Pegram, an employee of the physician-owned Carle HMO, found a mass in Cynthia Herdrich's abdomen. Instead of sending her to a local hospital at increased cost to Carle, Dr. Pegram recommended that Herdrich wait eight days for an ultrasound by colleagues within Carle's system. Herdrich's appendix ruptured. In her lawsuit, she charged that Carle failed its fiduciary function by directly influencing its physicians' decisions about medical treatment in such a way that caused her harm. It was a novel effort to find employer-sponsored health plans liable for their coverage decisions within the confines of ERISA, which requires its plans to act as fiduciaries in the best interest of their participants.

However, the Supreme Court refused to extend such a fiduciary duty to eligibility determinations. In a unanimous decision, Justice Souter distinguished between two major forms of health care decision-making—eligibility decisions made by health plan administrators to determine what services the plan might cover and treatment decisions made by providers regarding how to diagnose and manage patients' conditions. Justice Souter called Pegram's decision a "mixed eligibility and treatment decision"⁴³ where the question was not whether the ultrasound was covered, but whether the service was appropriate to use at that particular time. MCOs could not be held liable as a fiduciary, because that would strike at the very basis of managed care itself and "no HMO organization could survive without some incentive connecting physician reward with treatment rationing."⁴⁴

Despite dismissing the fiduciary claim, Justice Souter restricted MCOs' ERISA shield by separating the eligibility decisions from the mixed eligibility and treatment decisions. Whereas ERISA preemption clearly covers eligibility determinations, mixed decisions are not part of a health plan's administrative function. As a result, if MCOs or their agents make such mixed decisions, then it might be possible to hold them liable for negligence in doing so. Since Justice Souter did not set a clear distinction between eligibility and mixed decisions, it might be possible for MCOs' efforts to influence member physicians' practices to fall outside ERISA protection.

The Supreme Court again espoused a critical tone about MCOs in general, as Justice Souter critiqued their role in health care delivery and

42. *Pegram v. Herdrich*, 530 U.S. 211 (2000).

43. *Id.* at 229.

44. *Id.* at 220.

encouraged further debate about the need to oversee decision-making in the managed care system.⁴⁵ His dicta confirmed that the Court was monitoring ERISA's effect on the evolution of the American health care system and might now consider reexamining impediments previous decisions had placed on reform efforts.⁴⁶ The Supreme Court seemed to join the anti-managed care fray.

In two decisions in 2002 and 2003, the Supreme Court revealed a third approach to restricting the ERISA shield by expanding the "savings clause." In the first case, *Rush Prudential v. Moran*, an Illinois statute provided MCO enrollees the right to independent medical review if their MCO denied benefits they felt were contractually owed.⁴⁷ When Debra Moran had persistent pain and numbness in her hand, she sought to have a special procedure performed by a surgeon not associated with her HMO, Rush Prudential. Rush Prudential told her that it would only cover a more standard procedure performed by an affiliated physician. Moran sought independent review, but Rush Prudential denied her request and countered that the Illinois law that "relates to" administration of their benefits was preempted and invalid.

In a narrow 5-4 decision, the Supreme Court sided with Moran.⁴⁸ Rush Prudential lawyers argued that the independent review process was an illegal alternative to ERISA's system. MCO enrollees could avoid suing for the relatively meager ERISA statutory remedies by applying to a state-organized external appeals process. But Justice Souter, again for the majority, wrote that the "[e]ffect of eliminating insurer's autonomy to guarantee terms congenial to its own interests is stuff of regular insurance regulation" and therefore fell under ERISA's savings clause. He supported states' ability to enforce standards of reasonable medical care in the process of regulating insurance companies—as long as states do not come in direct conflict with ERISA.

The scope of the savings clause arose again in the context of another state law in *Kentucky Ass'n of Health Plans v. Miller*.⁴⁹ Most MCOs contract with specific providers to establish selective networks that only members can access. These contracts provide bargaining leverage for MCOs in negotiations with other providers looking to join the network. Kentucky passed a statute forbidding health insurers from discriminating against any

45. *Id.* at 221.

46. *Id.*

47. 215 ILL. COMP. STAT. 125/4-10 (1987).

48. *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002).

49. *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003).

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provider in a given coverage area who wanted to join the network and could meet the standard MCO conditions for participation.⁵⁰ The Kentucky Association of Health Plans claimed that ERISA preempted this so-called “Any Willing Provider” law.⁵¹

In a unanimous decision authored by Justice Scalia, the Supreme Court ruled that the state law fell under the ERISA savings clause. For a general law that regulates insurance to be saved from ERISA preemption, it only had to substantially affect the risk pooling arrangement, rather than control the actual terms of insurance policies.⁵² Though by 2003 many health plans had voluntarily stopped using selective provider networks to drive cost savings,⁵³ *Kentucky Ass’n of Health Plans* relaxed the savings clause requirements and left the door open for more state regulations to impact other MCO management tactics.

By limiting the “relates to” clause, separating eligibility from mixed decisions, and expanding the savings clause, these Supreme Court decisions seemed consistent in narrowing ERISA’s reach and expanding state influence over employer-sponsored health plans. Finding no legislative relief at the federal level, consumer activists and provider groups continued to work for local regulatory reform. Had ERISA been transformed from an “extraordinarily preemptive power”⁵⁴ and given way to allow MCOs to be subject to tort liability or state control? Many experts believed so. Bloche and Studdert arguably spoke for the majority of health policy analysts when they stated, “the Supreme Court has sounded an ERISA ‘all-clear’ for state regulation of plans’ management practices.”⁵⁵ But the Supreme Court had a surprise in store this past June.

A REVERSAL OF FORTUNE

Davila consolidated several cases that arose in Texas when enrollees in employer-sponsored MCOs attributed their injuries to the decision-making of their health plan administrators. After Ruby Calad underwent a hysterectomy with a rectal, bladder, and vaginal repair, the utilization review nurse for Cigna, Calad’s health plan, arranged for her to be sent

50. KY. REV. STAT. ANN. § 304.17A-270 (Michie Supp. 2003).

51. *Kentucky Ass’n of Health Plans*, 538 U.S. at 332-33.

52. *Id.* at 338.

53. Tanya Albert, *High Court Punches Another Hole in the Federal Law Shielding HMOs*, AMNEWS, Apr. 21, 2003, at <http://www.ama-assn.org/amednews/2003/04/21/gvl10421.htm>.

54. *Rush Prudential HMO v. Moran*, 536 U.S. 355, 376 (2002).

55. Bloche & Studdert, *supra* note 5, at 35.

home after a one-day hospital stay (contrary to the judgment of her doctor). Calad claimed that her early discharge contributed to the unspecified complications that arose a few days later and caused her to have to return to the emergency room.⁵⁶ In another case, Juan Davila suffered from arthritis and was prescribed rofecoxib by his physician. His Aetna HMO coverage required him to first try a less expensive non-steroidal anti-inflammatory drug such as naproxen. After three weeks of treatment with naproxen, he suffered severe gastrointestinal bleeding requiring blood transfusions and a five-day stay in a hospital intensive care unit.⁵⁷

Both Davila and Calad sued under the 1997 Texas Health Care Liability Act (THCLA), which requires MCOs to “exercise ordinary care when making health care treatment decisions” and makes plans liable for damages if they are negligent in meeting the ordinary care standard.⁵⁸ If the plan did not cover the desired health care service, then no liability could arise. The law thus sought to mirror the dichotomy between eligibility and mixed treatment-eligibility decisions set in *Pegram* and impose accountability accordingly. The plaintiffs claimed that their injuries resulted from such mixed decisionmaking. In response, the health plan lawyers invoked ERISA’s preemption over their claims and recast the claims in federal court to make the plaintiffs entitled, at most, to collecting the benefits denied—in Davila’s case, arguably the cost of a rofecoxib prescription.⁵⁹

The Fifth Circuit Court of Appeals gleaned a modern interpretation of ERISA preemption as one preventing states from exactly duplicating the terms of ERISA. Since ERISA provides a “means of collecting benefits,”⁶⁰ and THCLA provides a duty of reasonable care, the Fifth Circuit Court reasoned that the Texas statute fell outside of ERISA. It was a reading of ERISA so narrow as to make the statute completely toothless; no injured MCO enrollees would use the ERISA scheme merely to collect benefits. Rather, all would choose to sue for negligence and the resulting damages under state law.⁶¹

The Supreme Court rejected this opportunity to remove ERISA from the health care regulation equation. With the support of a unanimous

56. *Roark v. Humana, Inc.*, 307 F.3d 298, 302 (2002).

57. *Id.* at 303.

58. TEX. CIV. PRAC. & REM. CODE ANN. § 88.001-.003 (Vernon Supp. 2003).

59. *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2498 (2004).

60. *Id.* at 2499.

61. *Roark*, 307 F.3d at 310.

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court, Justice Thomas found that the issue of exercising ordinary care under THCLA was inextricably bound up in the administration of medical services under health plan contracts, which was ERISA's regulatory domain.⁶² Even though THCLA enforced a somewhat different duty than ERISA, the same set of facts could invoke both state and federal law under the Fifth Circuit's interpretation, so state law could be used to completely supplant ERISA. This would go against "Congress' intent to make the ERISA civil enforcement mechanism exclusive."⁶³

More significantly, Justice Thomas readdressed some prior Supreme Court ERISA health law holdings to cast them in a new light. He quoted liberally from the Supreme Court's 1987 cases, and once again classified ERISA as a "comprehensive remedial scheme."⁶⁴ He also closed the door that *Pegram* had opened with regard to mixed decisions. He considered the plan administrators' actions with respect to Davila and Calad as pure eligibility decisions, remarking that only a treating physician also acting as the administrator of health plan coverage decisions can make mixed eligibility-treatment decisions.⁶⁵ His decision effectively placed plan administrators' utilization review decisions back under the ERISA shield for liability purposes.

Finally, he invoked an overpowering federal policy implicit in ERISA to tighten the scope of the savings clause. He limited *Rush Prudential* to its facts, implying that the decision did not support the principle that states could freely formulate novel alternative forms of regulation outside of ERISA, such as independent appeals processes, without fear of preemption.⁶⁶ The dissent in *Rush Prudential*, also written by Justice Thomas, rejected Illinois' independent appeals law, in part due to ERISA's rejection of overlapping remedies.⁶⁷ A unanimous majority now directly invoked a position formerly held by a four-person minority—a sign of how critically the court may view other alternative remedies in the future. Justice Thomas did not even cite *Kentucky Ass'n of Health Plans*, perhaps reflecting his view that, with the Court's new perspective on ERISA, that case's reformulation of the savings clause was of minimal importance to future ERISA jurisprudence. Texas, as well as the other states with similar

62. *Davila*, 124 S. Ct. at 2497.

63. *Id.* at 2499.

64. *Id.* at 2500.

65. *Id.* at 2499.

66. *Id.*

67. *Rush Prudential HMO v. Moran*, 536 U.S. 355, 388 (2002) (Thomas, J., dissenting).

statutes,⁶⁸ found this effort to hold MCOs accountable for negligent coverage decisions to be invalid.

WHAT'S NEXT FOR ERISA HEALTH CARE LAW?

The language reinvigorating ERISA in *Davila* is hard to reconcile with the previous trend of cases limiting the reach of preemption, unless we impute to the Court an awareness of health policy. In *Davila*, the Supreme Court may have finally reached the end of how far it could stretch ERISA. More interesting, however, was the change in tone from previous discussions in *Pegram* or *Rush Prudential*. The Court retreated from language in those decisions that seems to favor local health care regulation over the business tactics MCOs use to administer care. Even Justice Ginsburg's concurrence agreed that the decision is "consistent with our governing case law," that "virtually all state law remedies are preempted," and that the Court's hands were tied by the federal ERISA law as currently framed.⁶⁹ These words should strongly discourage future efforts to reinterpret ERISA at the state legislative or judicial contexts, and we are not likely to see another *Davila*-like case soon. Instead, patient advocates will likely turn their efforts towards federal legislative reform of the ERISA statute itself.

Our explanation for this swing is that the Supreme Court was uncomfortable at the vanguard of the anti-managed care movement. As discussed in the introduction, the Supreme Court, in its own decisions since 1995 and the direction it therefore gave to lower courts, had helped restrict managed care by limiting ERISA preemption. As increased litigation gave voice to the public backlash, stockholders lost interest in those insurers who persisted in capitated managed care.⁷⁰ Managed care collapsed, to be replaced, at least in the rhetoric of health policy, by consumer-driven health care.

But consumer-driven health care has its own problems. First, the theory of consumer choice relies on competitive markets, and there are few signs that such market conditions are developing in the health care

68. At least ten other similar state statutes have been adopted. *See, e.g.*, Managed Health Care Insurance Accountability Act of 1999, 1999 Cal. Legis. Serv. 536 (West); *see also* Anne Gearan, *High Court Hears Test of Patient Protection Laws*, LEGAL INTELLIGENCER, Mar. 24, 2004, at 4.

69. *Davila*, 124 S. Ct. at 2503 (quoting *DeFelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 456 (3d Cir. 2003)).

70. *See* CHARLES BOORADY ET AL., HEALTHCARE SERVICES: MANAGED CARE (2000).

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sector.⁷¹ Second, the central features of consumer choice are higher co-payments and deductibles, which represent the thinning out of employer-provided insurance. Reduction of employee benefits is a major theme in the effort to make American companies more competitive,⁷² but this creates problems with access to care and is only a short-term solution to limiting costs. As a result, Robinson has warned that the consumer-driven approach will not be sufficient to control costs and improve quality; some aspects of managed care will have to be revived.⁷³

Perhaps then, in *Davila*, the Supreme Court was being appropriately cautious in not allowing the Texas law to take a further step to cripple the business model of managed care. More to the point, as Justice Ginsburg's concurring opinion relates, the key guidance on health policy must come from Congress, which has done little recently to address ERISA.⁷⁴ Judicial capacity to address such complex issues is limited,⁷⁵ and the Supreme Court's insistence in other cases that it must defer to administrative expertise in health policy indicates that it recognizes this.⁷⁶

Our view of the Supreme Court, then, is that the Justices are more aware of the role their decisions play in health policy than has previously been appreciated, and their intent for now is not to be activist. The effort to reverse course and halt the momentum of the attack on ERISA is important evidence that the Supreme Court will not allow itself to be the instrument of health care reform. That is a role it wants to defer to the legislative branch, as the role of consumer choice, and the re-emergence of managed care, define the policy battleground in the effort to reduce health care costs.

71. Bloche & Studdert, *supra* note 5, at 39-40.

72. Micheline Maynard, *United Appears Boxed in as Trouble Percolates*, N.Y. TIMES, Aug. 1, 2004, at C1.

73. Robinson, *supra* note 4, at 1886.

74. See *Davila*, 124 S. Ct. at 2503; Gail B. Agrawal & Mark A. Hall, *Managed Care Liability Beyond the ERISA Shield*, 47 ST. LOUIS U. L.J. 235 (2003).

75. See Michelle M. Mello & Troyen A. Brennan, *The Controversy over High-Dose Chemotherapy with Autologous Bone Marrow Transplant for Breast Cancer*, 20 HEALTH AFF. 101 (2001).

76. See Michelle M. Mello et al., *The Pharmaceutical Industry Versus Medicaid—Limits on State Initiatives To Control Prescription-Drug Costs*, 350 NEW ENG. J. MED. 608 (2004).

